ORGANIZATIONAL ASSESSMENT AND RECOMMENDATIONS CHERRY HOSPITAL

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INTRODUCTION

On September 10-12, 2008, a team of senior healthcare executives conducted an assessment at Cherry Hospital in Goldsboro, NC. The focus of this assessment was to evaluate leadership processes, management of operations, diversity issues, clinical care, patient care model, and compliance with applicable hospital standards. The assessment followed the hospital's removal from the Medicare program following an unsuccessful survey by the state survey agency. Although the consultation was focused on the ability of the organization to recover from the decertification and regain Medicare certification, the primary focus of the assessment was the resiliency of the organization to respond to the need for change. Ultimately, the organization's culture, its norms and values, were assessed as facilitators and obstacles to change.

This report summarizes the findings from this assessment. Data were gathered through interviews with key staff and executives, staff focus group sessions, observations of clinical care, inspection of the physical environment of care and support services, and the analysis of documents presented for review, including medical records. Although it is not possible to conduct a thoroughly comprehensive assessment in a compressed time frame, the review detected overarching issues that affect the organization's ability to rapidly correct the serious deficiencies that were identified in the CMS report.

LEADERSHIP

One of the primary responsibilities of senior leadership is to shape the organization's culture, so that high-quality care can be provided in a safe patient care environment. The leadership of Cherry Hospital has expressed its commitment to a culture of positive clinical reform (i.e. moving from physical control to a therapeutic model). However, this new culture has not successfully taken hold at the unit staff level throughout the hospital and, in particular, among the healthcare technicians. The leadership's failure to bring about the transformation may arise from poor communication. The hospital's leadership has chosen to communicate its reform message primarily via print media vehicles with limited direct face-to-face communication or personal involvement in providing instruction and oversight. Besides failing to demonstrate the strength of the leaders' commitment, limited communication can lead to misinterpretations among key groups. Insufficient clarity about new policies and practices further complicates understanding about the roles of different clinical groups. Furthermore, inadequate supervision contributes to a lack of reinforcement of key messages. Confusion and misinterpretation lead to noncompliance with policies and inconsistent patient outcomes. Unfortunately, the failure to enact the clinical reform initiative results in continued risks to patient safety.

Specifically, staff spoke about the heavy use of email to communicate important messages. Because email is a poor medium for communicating relative importance of the subject, an important message may be lost in an ocean of emails. The inability to decipher meaning or priority contributes to delayed action or, in the worst case, inaction in response to the information presented. Email may have a role in confirming prior communication or to follow up on a prior assignment, but as a primary communication tool, it is not an effective leadership tool.

Leadership in response to negative outcomes and measures is also inadequate. The organization's responses to regulatory findings are largely focused on education and policy modifications that read well on paper, but there is no evidence that a monitoring program will be implemented to demonstrate that these changes are integrated into care. Policy change and training are documented as completed corrective actions, rather than demonstration that the necessary changes were consistently put into practice, which is the necessary indicator of compliance. Outcomes, not activities, are the appropriate response to identified deficiencies. Discussions with key staff indicate a good knowledge of how things are "supposed to be" from a regulatory perspective, but questions remain as to whether the same individuals have the ability to effect the change they articulate. The recent shift from a "correct answer" approach to a "show me" approach, apparent in both the CMS and Joint Commission survey processes, is likely the reason for the sudden exposure.

Although the focus of the assessment was not the clinical quality of psychiatric care, Medical Staff peer review as a leadership function was evaluated. A few cases were identified that would normally have been submitted for peer review, but it was discovered that no reviews were conducted. Examination of cases that were peer reviewed suggested that the Medical Staff avoids finding any errors or need for changes, even when indicated. This type of observation is not uncommon when the Medical Staff views peer review as "coming after someone for doing something wrong." This sentiment arises because Medical Staff peer review feeds into the privileging process. An equally important aspect of peer review, however, is its ability to provide an opportunity to learn from an unusual or undesirable clinical outcome. When conducted properly, peer review can result in process or policy changes within the Medical Staff function and related clinical areas of concern. Appropriately, external peer review is obtained whenever the Clinical Director is the physician in charge of care.

MANAGEMENT

The functional operation of the organization reflects the silos of the organization's structural chart. Despite the multidisciplinary nature of modern psychiatric care, members in the organization operate in isolation, with little regard as to how actions effect other departments or groups. Changes to policies, new regulatory requirements, and recommendations for changes in approach are announced, rather than discussed, leading to a mandate that is met by resistance, resentment, and at times, inaction.

The physical distance between units and departments hinders the activities of managers. Some staff members welcome the managers as if it has been some time since the last visit, while others are familiar with their presence on the unit. This indicates to the observer that the amount of supervision varies between units. The absence of regular contact with supervisors discourages adoption of behavioral changes among staff.

The lack of presence of managers at the point of care is problematic from both a leadership and a compliance perspective. Compliance with law and regulation is largely a remote process, driven by a problem-focused approach. When requested, managers will take action to correct regulatory deficiencies. However, there does not appear to be a norm that recognizes the need to proactively address standards to assure compliance with existing standards and aspire to a

higher quality of care when warranted. Further, the responsibility of resolving problems is generally assigned based on the organizational chart. Ideally, these responsibilities should be shared and assigned on the basis of functionality. Collaboration on shared problems is the exception, rather than the rule, except when collaboration is a specific requirement of the mandate.

There is currently no structure in place to support quality. A recent initiative by the Executive Director resulted in a structure that can support accountability for quality of care, satisfying regulatory obligations. However, this structure lacks an oversight function for quality, which would address gaps in performance and establish expectations for better outcomes. The structure has yet to be implemented, and it is uncertain to what degree members of the leadership have embraced it and believe in its ability to transform quality in the organization.

The centralized structure of nursing management is a barrier to successful implementation of change. The absence of a global approach to staffing limits opportunities for better resource management. Staffing and resources are allocated by position, not according to the acuity and needs of patients. A management structure that resides closer to the point of care would provide needed perspective to manage staffing *vs.* patient needs and react appropriately when those needs change. An audit of nursing positions is recommended to evaluate the distribution of resources across the organization.

Although not controlled at the hospital level, compensation is an important management system that contributes to staff performance. State mandated pay structures and scales are felt to contribute to barriers to change in the organization. Both leaders and staff expressed the opinion that pay levels for healthcare technicians were inadequate to keep good technicians. The concern over technician pay is expressed not only by the technicians themselves, but also by the nurse leadership, executive leadership, and even non-clinical staff. According to staff interviews, salaries do not increase through merit raises, only with cost of living adjustments or position changes, such as a change from technician to lead technician. It is felt that this is one of the major reasons that efforts to change the way direct patient care is delivered have met with failure. Several people reported that technicians can leave the hospital to work for another state agency for higher pay. Good technicians leave to pursue better paying opportunities, while those who are more complacent and less attractive to other employers, remain at the hospital. The pool of HCTs becomes filled disproportionately with a high percentage of low performing people. New employees are more likely to be influenced by low performance HCTs, rather than high performance HCTs. Ultimately, this pay structure fosters poorer performance, rather than better (patient-focused) performance. Keeping good technicians requires that they are rewarded financially for demonstrating better skills and judgment in their work. Similarly, nurses have little opportunity for pay raises with increased experience. Unlike other hospitals that have career ladders and pay associated with increased competencies, nurses enter Cherry Hospital fairly paid, but wage compression decreases the desirability of continued service. While longevity has advantages, the pay system should reward competencies, not just seniority.

Pay problems are exacerbated by a new payroll system that has resulted in numerous errors for all employees. This is especially disheartening when staff has been subject to mandatory overtime, which has not been paid correctly. Compensatory mechanisms for recognition of good work, awards for accomplishments, and other forms of relief are rarely seen.

CLINICAL CARE

The informal organizational structure at the point of care is inconsistent with the expectations of regulatory agencies. The expected model of a treatment plan written by a physician, guided and supervised by the nurse and other licensed professionals, and assisted by supportive personnel has been replaced by task-focused lists of activities disconnected from the elements of the treatment plan. While this approach assures that certain tasks are accomplished equally for all patients, it does not promote individualization of the treatment plans to improve outcomes for patients.

Task-focused activities at the point of care are well documented. Charting reflects most elements of the treatment plan, with opportunities for improvement seen in nutritional support and assessment of individual needs (such as pain reassessment). The largest opportunity for improvement seems to be in the documentation of progress towards outcomes of treatment. While activities and routine care are documented, there is poor documentation of actions taken to assist patients with the life skills necessary to function in the post-acute setting. Discussions of psychological status, thoughts and concerns, and discharge planning are limited to care conferences and not reflected in daily care on the units. While patients receive treatment in structured sessions, some patients do not participate in these activities and may therefore not receive assistive support while on the unit. Unit observation indicated that the treatment plan is largely guided by unlicensed personnel outside of formal groups. It is uncertain how each patient's direction of care is communicated among staff on an ongoing basis. The emphasis on task-focused care and a lack of attention to patient outcomes lead to the conclusion that patients are more commonly "housed," rather than treated at the organization.

Further review of documentation also revealed little attention to patients' physical outcomes. A patient with an admitting weight of 163 pounds lost 10 pounds in the first month (152.6 pounds) and then gained nearly 17 pounds in the next week (170 pounds), with a return to 160.6 pounds three months later. Gaps in the monitoring of patient weight and the lack of attention to changes in patient condition could place patients at risk. There is a similar lack of monitoring for constipation, even in patients with known problems with constipation. The prioritization of routine over patient needs is also evident in the management of diabetics. Patients routinely receive morning medications with a grape flavored punch that is essentially a sugared drink, devoid of nutrients. In addition, patients receive a morning juice break and an afternoon snack. Patients with orders for "push fluids" are offered their juice of choice throughout the day. During a patient tracer, a diabetic patient received approximately 6 oz of grape punch, then requested three juices (only one of which was given because the unit had run out of the requested juice), and received juice during the scheduled juice break. Discussions with the dietician revealed that only the one juice break was figured into the diet and that no dietetic alternatives were available to diabetic patients. This example not only illustrates how staff unconsciously place patients at risk, but also shows the failure to follow the physician orders (2000 calorie diet).

Although staff reported that a restrictive intervention is often needed at the organization, no opportunity to review such an event was available during the visit. It is uncertain whether this lack of an incident of restrictive intervention is reflective of increased staffing or the Hawthorne effect. Patients with specialized needs, such as those known to have violent behavior, did not

appear to have specialized treatment plans to assist them in controlling behavior outside of chemical intervention. No examples of formal behavior modification programs, point systems, or privilege levels were seen.

During a unit visit, a patient was reluctant to attend a scheduled formal group. Several attempts were made to persuade the patient to attend. Following three attempts, an "intervention team" code was paged overhead to the unit. This page was reportedly broadcast across the entire building. Patients and staff responded en mass to the gathering area on the unit. The sudden appearance of so many people raised the anxiety level in the milieu. The effort was unsuccessful. This example brought into question the degree to which staff efforts to execute a therapeutic intervention (such as the use of social pressure) actually incur the opposite effect by creating an environment that promotes an intimidating response (physical intimidation by a show of force). This may be further encoded in patients when the usual outcome of the sudden appearance of multiple staff is a "take down."

While staff reported that restrictive interventions are common, the organization did not present data on the incidence of therapeutic interventions that avoided restriction and those that ultimately required restrictive interventions. Data was presented that showed decreases in the use of restraint and seclusion. However, the reports did not include information about the use of therapeutic (preventative) measures as primary interventions towards proactively avoiding the use of restraint and seclusion. Although the Joint Commission requires debriefing following restrictive interventions, the debriefing documentation was limited to the patient's response to the episode, with little to no information from staff regarding review of the situation, prevention elements, and modifications to the treatment plan. This lack of debriefing by the care team not only results in an incomplete care plan for the patient, but also represents a missed opportunity for episodic learning and correction of inappropriate actions. Further, the security cameras represent an untapped resource for learning and improvement, even if only used on an occasional basis. Documentation following restrictive interventions is also primarily focused on behavior, with little information about physical status available. Problems with the debriefing process have been previously identified by regulatory agencies, but opportunities for improvement remain.

The Nursing Service Department has several layers of nursing supervision in place for oversight of patient care. Information derived during interviews with the DON, ADON, Nurse Managers, and Nursing Supervisors indicates there have been many attempts in the past years to make changes in which Registered Nurses would provide direct patient care on the units, and Nurse Managers would have closer relationships to specific assigned units. Each attempt at change was deemed a "failure," and the "old way" of providing patient care was resumed. At this time, the Lead Healthcare Technician provides the majority of direct patient care. The Lead HCTs direct other HCTs in tasks that must be completed, such as filling out 1:1 observation checklists or similar documentation. The RN's role on paper, and by licensure, is to oversee both of these positions. However, it was clearly indicated that many RNs choose not to provide oversight, allowing the HCT to make decisions directly related to patient care. Observation of staff on the unit revealed Lead HCTs bringing documentation forms to nurses and pointing to areas on the form, followed by nurses signing quickly, with little attention to the content of the form. Information from observation and interviews revealed that nursing supervisors spend little time

on the units observing and/or participating in direct patient care. Response to emergencies remains the common exception, although it is unclear what role the supervisors play in assuring monitoring or follow-up of patients involved in incidents or restrictive interventions.

The Nursing Department is using a large amount of agency staff. Further investigation revealed that many of the agency staff members (31) serve in the HCT role, and fewer (10) serve in the RN role. The HR department indicated they had many applicants for HCT positions; it is unclear why the organization is using agency HCTs. It was noted that on a given day, there are a significant number of HCTs assigned to 1:1 interventions with patients. An examination of the daily schedule on the psych rehab unit revealed 13 HCTs to care for 22 patients. Five patients were on precautions, one patient required an escort for dialysis. As a result, 7 technicians were available for 17 patients. Leaders in the organization stated that the goal staffing is 1:5 for technicians. An additional 2 nurses were also present. It was important to note that two of the HCTs were agency staff. Upon questioning, the manager indicated that the agency staff could not be cancelled when not needed. Despite these high staffing levels, nursing staff inconsistently oversaw interventions towards fall prevention.

There did not appear to be any performance improvement activities surrounding patterns, trends, or success of 1:1 interventions. While each episode is properly ordered by a physician, it is uncertain whether there are opportunities to decrease the use of 1:1 interventions through improvement in the therapeutic environment. It is also unclear whether intervention is being used appropriately as a failsafe measure to keep patients safe. More data is needed before conclusions can be made.

Overall, the Restrictive Intervention policy is good. The area of greatest concern is the allowance for "properly trained staff" to initiate a restrictive intervention, and to continue to use the restrictive intervention for up to 15 minutes. The RN is to be notified immediately (within 15 minutes) of the restrictive intervention to assess the patient and notify the physician. NCI Therapeutic Holds are widely used across the hospital. However, the concept of not laying hands on patients as the primary intervention clearly has not been communicated. Patient and employee injuries are alarmingly high. It is obvious that therapeutic holds and injuries are directly related, but little data analysis has been used to relate the two variables. Unfortunately, a false sense of success exists because overall seclusion and restraint hours have decreased. The chemical restraint portion of this policy is fairly well written. However, interviews reveal that there has been a difference of opinion as to whether a chemical restraint is "restrictive." This confusion leads to inconsistent application of the policy, and possibly, over- or under-use of medication for patients. Restraint data should also be examined in light of this confusion to ascertain whether the decrease in restraint use was a result of "unclassifying" chemical restraints, which is not consistent with CMS guidelines.

Medication use processes in the organization are not consistent with regulatory expectations. Controlled substances are maintained in a manner that does not prevent diversion and could place patients at risk. A similar issue was identified during previous regulatory visits. Monitoring of the effectiveness of medications is largely documented through routine tasks conducted by the HCTs and is not based on individual actions related to medication administration. Little information about whether behavior improves as therapeutic medication levels are attained can be compiled from nursing notes. Documentation by the physician

assistants of the patients' medical condition is good, but documentation of physical condition is largely dependent on which physician assistant sees patients on an "as indicated" basis only. The physical condition of patients is not documented daily by nursing staff.

CHANGE MANAGEMENT

During the opening conference, leadership staff reported that a recent cultural change was leading the organization away from "control of the physical environment" and toward the fostering of a therapeutic environment. This is consistent with recent state-wide changes in the outpatient arena. Limited success was documented towards this goal.

While the organization has demonstrated the ability to make some changes, such as improving compliance with dashboard indicators, there is no routine attention paid to improving quality at the point of care. Gaps in compliance with debriefings, use of restrictive interventions, assessment, and medication use are not brought to the attention of front line caregivers so that learning is a regular part of care and activity. While staff members are eager to point out opportunities for change and improvement of processes – both care-related and staff-supportive – they do not seem to feel able to act through established mechanisms or grass roots efforts. Staff at the leadership and managerial level are not encouraged or rewarded to improve care outside of "endorsed" projects. A staff member showed surprise upon receiving an invitation to be part of a performance improvement committee.

Several examples of failed attempts at change were gathered. The rapid assessment of the causes of failure revealed implementation errors related to communication and post-implementation management. Communication errors may have been due, in part, to the lack of leadership training or training on the effective facilitation of change for the hospital's nursing management. As a result, there has been confusion, misunderstanding, and frustration among both the management and staff regarding how to implement major clinical reform initiatives into day-to-day operational practices and decision-making. This frustration could be leading to the incidences of patient neglect and abuse. A hypothetical example of such a chain of events appears below.

1. The nurse manager interprets a new reform directive to mean that certain practices by the healthcare technicians must be discontinued.
2. The healthcare technician does not understand why these practices must be discontinued or what alternatives can be used and, thus questions the nurse's direction.
3. The nurse misinterprets the technician's questions as disrespect and insubordination. The nurse responds with a zero tolerance stance and/or disengagement from supervisory responsibility for the technicians.
4. The healthcare technician feels disrespected by the nurse and, ultimately, unsafe with the patient because familiar tools have been taken away, no reasonable alternatives have been provided, no supervision is available to assist with his or her uncertainty and, because there is no tolerance for incorrect decisions or actions, he or she also fears income or job loss (loss of psychological safety).
5. Extreme frustration over a perceived loss of influence and control over the patient care environment and employment situation compel the healthcare technician to engage in irrational behavior, such as using overly aggressive physical control in managing patients to protect one's self or overly passive participation on the unit to protect one's job.

While the above scenario is clearly fictitious, it illustrates how quickly the patient care environment can spiral out of control when proper communication techniques are not deployed at the outset of any significant change. Furthermore, management techniques must be used after implementation to provide message reinforcement, address questions, and measure compliance and effectiveness. Drawing from responses in interviews and focus groups, the ineffective implementation of efforts to create a more therapeutic and less controlling environment has generated feelings that the staff is disrespectful, insubordinate, and threatening, while staff members have come to view management as disrespectful, uncaring, and absent.

Senior leadership is rarely seen "walking around" the clinical areas. The design of the hospital, with multiple buildings distributed across the campus, creates an obstacle to senior leaders being seen. Visibility is critical for change management, especially when the staff is demoralized by bad press reports. The importance of being seen means that the leadership needs to overcome this inconvenience. Campus logistics present a huge barrier to communication and supervision, but can be overcome by challenging old behaviors.

Due to time constraints, there was not sufficient time to adequately evaluate the strengths and weaknesses of each senior leader individually. However, these leaders have not demonstrated that they are collectively up to the challenge of managing organizational change. Changing the organization's culture is a leadership team effort, not an individual effort. It is noted that all the senior leaders have been in place less than three years. Leadership instability interferes with mounting a sense of urgency. In addition, changing the players will not, by itself, create a leadership team strong enough to enact the changes quickly. **It is clear that the current leadership team needs help to alter the culture and become a more effective leadership team.**

GOVERNANCE/ OVERSIGHT

According to the Bylaws of the Hospital, "the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse shall be the Governing Body for the hospital." This authority has been delegated to another Division executive. The Executive Director submits a Quarterly Report to the Chief, State Operated Facilities that includes a substantial amount of information, but there is no evidence that any unacceptable findings in the report are acted upon. The report includes neither meeting minutes, nor memos that document board actions or responsibilities, as required by the COPs. For example, past reports indicated persistent problems, such as staff injuries, but the Executive Director could not provide any documentation indicating that the board initiated or approved any corrective action plan. There was no evidence that the required plans and reports, which are supposed to be reviewed and approved by the board, were actually presented. Most notable is the absence of board action on the appointment of physicians to the Medical Staff and performance/quality data. Furthermore, there was no evidence that the PI Plan had been approved.

The Governing Body's failure to provide oversight of quality is a critical aspect of the deficiencies cited during regulatory reviews. Review of the regulatory reports for the organization over the past two years reveals recurrent regulatory deficiencies, some of which were demonstrated during the visit. This finding is likely due to the combination of lack of oversight by the Governing Body and the assignment of individual departments or managers to a particular problem in isolation. While the manager responds appropriately to the regulatory finding during the immediate post-survey follow-up, no accountability mechanisms exist to assure that processes are resistant to regression.

Replacing a board with a single executive eliminates the diversity of opinions that comes with a well-designed board. Board members should be able to contribute new insights into issues. New and varied insight ultimately enables the development of better planning and reduces the likelihood of tolerating inadequate improvement. Board members are uniquely positioned to challenge "the old way" and force leaders and managers to question existing norms and look towards new ways to accomplish better outcomes. This structure provides a "safe zone" for leaders and clinicians to replace problematic processes with new ideas focused on patients, rather than job protection.

ORGANIZATIONAL CULTURE

Interviews and focus groups were conducted with staff members to identify attitudes and norms that are embedded within the workforce. These sessions were also helpful in assessing staff attitudes to the organization's leaders.

Personal safety is a major issue. Even the biggest and most loyal employees expressed a sense of fear for their personal safety. They blame senior leadership for ignoring the need to have better procedures for dealing with combative patients. As an example of the cultural problems, several employees expressed the desire for a larger police force with a greater role in "takedowns." This approach is clearly contrary to the overall safety for patients and staff.

Personal safety issues also influence the reporting of incidents. Staff members stated that fear of retribution from other staff members allows events to go unreported. This is another cultural norm that needs to be reversed. Low incidence of reporting may also be influenced by the perceived sense that "nothing will change." Performance improvement activities that occur following events are largely reactionary and do not represent an ongoing commitment to improvement through examination of events, whether major or minor in nature.

There seems to be little pride in working for the hospital. Long-term employees express embarrassment over the newspaper articles and admit to not wearing their badges in public. Both staff and management argued for more local control over media relations. Senior management said that the local press was more favorably inclined to Cherry Hospital. Senior management believes that the local press would be willing to balance the reporting by carrying stories about good things that are working right at Cherry Hospital. Without pride, employees feel disempowered and hopeless. Leadership must work to re-instill a sense of pride in the employees. This requires both physical visibility, and visibility in promoting positive messages.

Staff reported that senior management has fostered an environment of suspicion. This was intensified by the installation of cameras in all public areas. Although there are many good management reasons for installing this system, it has primarily been used to investigate complaints. Consequently, employees perceive that the purpose of the system is to "catch someone doing something wrong." The misinterpretation of management's intent is another example of poor communication. It also highlights the cultural norm that patient safety is a lower priority than job security.

Proper staffing is a concern, which we believe reflects limited familiarity with other psychiatric hospitals. Many staff members expressed concern that staffing was too low. During observation, it appeared that the staffing level may indeed be appropriate, but that the mix and assignments could be improved. There should be a thorough analysis of staffing requirements.

Human resource issues affect the ability of the organization to effect change and improve its ability to provide care. The violence within the facility raises several concerns. First, does the recruitment process adequately screen employees for personality traits that are necessary to work in this stressful, patient centered environment? Second, how well does the organization provide initial and ongoing education and coaching to its employees? Finally, is the organization able to retain good employees and weed out bad employees?

Our assessment is that the organization is weak in all three of these areas. Furthermore, we believe that state employment regulations influence each of these issues and that the board needs to assist the hospital either in achieving effectiveness within the constraints, or working to alter the constraints. It is not in the best interest of patients to leave this problem solely in the hands of hospital administrators.

Leaders and staff also expressed a great deal of hopelessness regarding the disciplinary process. Although the data does not indicate that this occurs, there is widespread belief that appropriate disciplinary actions have been overturned at the upper management or State level. When this occurs, it effectively places an identified "bad apple" back into the patient care environment. Besides the obvious risk that this creates for patients, the returning employee often feels not chastised, but emboldened to continue bad behaviors, influence other employees, and menace the work lives of those who would enforce standards of behavior. The net result is that staff and leadership are slow to report or take action against inappropriate behavior on the units. This is a significant problem from a cultural perspective, because returning these workers to patient care positions communicates to staff that the employee's rights supersede patient safety.

One area that we did not find to be a significant issue is racial tension. Based on the review of employee hiring retention and promotion trends, focus groups, and one-on-one interviews, we have concluded that there are no overriding diversity or cultural competence issues that appear to be driving the current staffing and patient safety issues. Hiring retention and promotion statistics closely mirror the patient and community populations. Focus group and interview feedback consistently points to occupational, professional, or grade level differences as the primary reasons for the internal conflict that is currently experienced. Hospital leaders do not trust the staff to take proper care of the patients and, to some extent, they are intimidated by staff presence and control on the units. Staff members, on the other hand, distrust leadership's ability to give good and consistent direction. Staff members also distrust leaders' use of the

disciplinary process when conflict occurs. Specifically, healthcare technicians have expressed the perception that nurse leadership takes a zero tolerance approach to discipline and will try to remove technicians unfairly. Such behavior or perceived behavior has, in turn, created an environment where frequent grievances and appeals are filed and approved up the management chain. However, none of this type of behavior has been portrayed as having any racial, cultural or ethnic overtones or biases.